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ABSTRACT

As part of a study of the career contingencies of the rehabilitation counselor, an examination was made of the role, membership patterns, and goals of three professional associations--the National Rehabilitation Counseling Association (NRCA), the American Rehabilitation Counseling Association (ARCA), and the American Psychological Association (APA). Some preliminary conclusions were: (1) Association memberships differ greatly according to the institutional milieu in which counseling tasks are performed, with Veterans Administration personnel in APA, State Vocational Rehabilitation counselors in NRCA, and private agency workers divided fairly evenly among the three associations, (2) The analysis of professional association affiliations in different work settings and regions suggests that there is no single organization which can speak for the needs of rehabilitation counseling as an emerging profession, (3) Training requirements differ by institutional setting, and (4) A future trend may be to consider counseling as an occupational entity, with guidance counseling, employment counseling, rehabilitation counseling, and the like as specialties. (SB)

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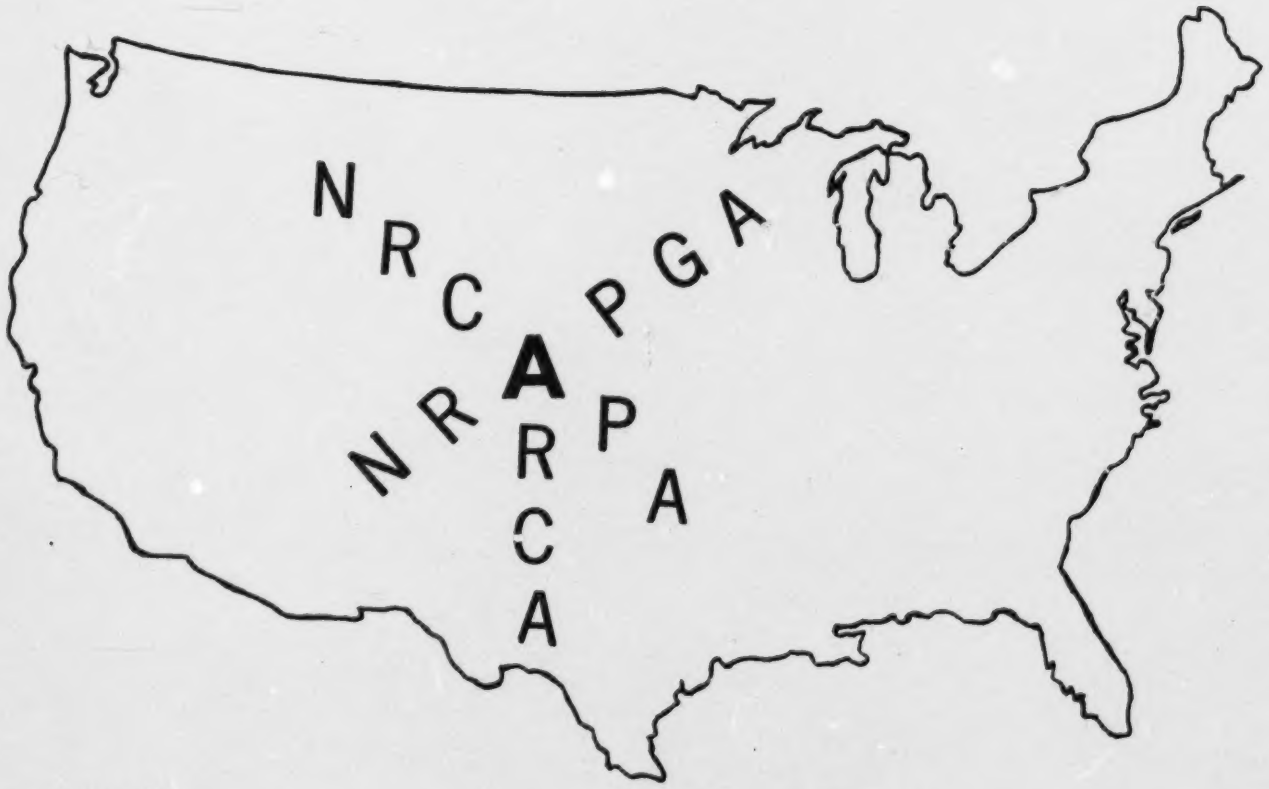
Professional Associations and Memberships in Rehabilitation Counseling



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PROFESSIONAL ASSOCIATIONS AND MEMBERSHIPS

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REHABILITATION COUNSELING

Working Paper No. 2

CAREER CONTINGENCIES OF THE REHABILITATION COUNSELOR

Professions Project
A Program of Research on Occupations and Professions in the Field of Rehabilitation

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Marvin B. Sussman, Ph.D.
Project Director

Marie R. Haug, M.A.
Project Coordinator

Gloria A. Krupnick, B.A.
Research Assistant

Department of Sociology and Anthropology
WESTERN RESERVE UNIVERSITY
Cleveland, Ohio

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PREFACE

The Sociology Department of Western Reserve University in cooperation with the Vocational Rehabilitation Administration is currently conducting a study of the career contingencies of the rehabilitation counselor. As a part of this research, an examination was made of the professional associations of counselors.

This paper contains a general statement on the role of the professional association in the field of rehabilitation counseling, an analysis of membership patterns of counselors, and a short discussion of the goals of each of the three professional associations in rehabilitation counseling.

TABLE OF CONTENTS

		Page
I.	Introduction	1
II.	The Role of the Professional Association	1
III.	Problems of Professional Associations in Counseling	3
IV.	History of the Professional Associations in Counseling	4
V.	Membership Patterns	8
VI.	Conclusions	26

I. INTRODUCTION

A rehabilitation counselor is one involved in "a process in which the counselor thinks and works in a face-to-face relationship with a disabled person in order to help him understand both his problems and his potentialities, and to carry through a program of adjustment and self-improvement to the end that he will make the best obtainable vocational, personal and social adjustment."[1] According to this definition, many people are engaged in rehabilitation counseling, despite such varying titles as counseling psychologist and social worker. Also rehabilitation counseling is performed in a variety of settings - Veterans Administration Hospitals and Benefits offices, rehabilitation and general hospitals, and private and state agencies of vocational rehabilitation. Further, there is some relationship between the use of different titles and the various institutional settings in which rehabilitation counseling is practiced.

Examined in this paper are the professional association memberships of three groups of counselors: (1) counseling psychologists and other psychologists in the Veterans Administration who do rehabilitation counseling at least one-third of their time; (2) rehabilitation counselors, counseling psychologists, nurses, social workers, and other personnel from private service agencies and hospitals who perform counseling for at least 20 percent of their time; and (3) rehabilitation counselors, coordinators, and special counselors, including supervisory personnel, from the State Divisions of Vocational Rehabilitation.

The professional associations considered of major relevance to the field, and therefore included in the examination of counselor affiliations, are (1) The National Rehabilitation Counseling Association, a division of the National Rehabilitation Association; (2) the American Rehabilitation Counseling Association, a division of the American Personnel and Guidance Association; and (3) the American Psychological Association.

II. THE ROLE OF THE PROFESSIONAL ASSOCIATION

A professional association may be defined as an organization of individuals engaged in the same work whose objectives include setting standards for practice and entrance into the field through control of the educational process, self-regulation of members' behavior, and political activity to establish a position within the body of professions and to create a public image of professionalism. The image contains notions of an orientation of service to others, based upon a scientific body of knowledge.

Professionalization of an occupation is accompanied by the establishment or strengthening of a professional association for the purpose of regularizing the relationships between practitioners, practitioners and clients, and practitioners and society.[2] Regulation becomes a professional activity; the profession attempts to claim or strengthen a mandate to control itself rather than permitting itself to be controlled by society.[3] In convincing the public of its right to this mandate, the association may

find it necessary to engage in extensive political lobbying for certification, licensure, and legal definition of relationships with other occupational systems. If the occupation is unknown to the public, an excellent public relations program is usually required.[4]

Professional organizations are voluntary associations, but the individual who does not join may find it difficult to advance his career within the field. On the other hand, since the association functions primarily to further the profession, members of the profession who are not members of the association may derive some unearned benefits from its work, especially in improved relationships with clients, higher salaries or larger fees, greater acceptance by the public, etc.

The association provides the sustained motivation necessary for good performance as well as social and moral support to the individual practitioner. These functions are particularly necessary in salaried professions such as rehabilitation counseling, where the individual does not have control over his work situation, especially his relationships with his client, and must rely therefore on some group to protect his interests and those of his colleagues.

The association is constantly trying to upgrade standards and may encounter resistance from workers within the field who feel threatened by higher levels of practice. To cope with this, professional associations usually have a "grandfather" clause allowing membership within the association for all individuals in practice prior to the certification or licensure period. Unfortunately, this combination of the "more" and "less" professional within the same organization sometimes leads to disagreement, during the early period of transition, on the nature of the professional role as well as the role of the professional association.[5] In time such conflicts are dissipated as a consequence of movement of old-time practitioners into other fields, retirement, or death and the emergence of a new generation trained under the higher standards.

Research, demonstration, and dissemination are activities to improve practice, self-regulation, and image of members of the emergent profession. Research is often sponsored by the professional association, and technical journals for dissemination of new knowledge in the field as well as "house organs" or newsletters for information about the profession are usually published by the association.

The professional association assumes responsibility for training and education in its field. It does this by setting up standards for entrance and requirements for graduation into the field which all aspiring practitioners must meet. Where certification or licensure is demanded, legislation and institutional arrangements are necessary, e.g. examiners for the legally constituted authorities. A strong connection between training institutions and the professional association develops, with educational leaders holding officerships in the association, while practitioners may do a "stint" with the academic institution. The movement between practice and training areas, combined with the integration of training, practice, and professional activities, results in control of the socialization process into the profession. Education is not limited to new students. Programs of continuous education are sponsored by the association in such forms as workshops, seminars, and conferences. These are intended to upgrade standards among incumbents, disseminate new knowledge concerning practice, re-define competence, and reinforce the service ethos.

Often professional associations come into existence by a process of differentiation from older established groups, or as a result of the actions of such groups. The formation of the American Rehabilitation Counseling Association as a sub-body of the American Personnel and Guidance Association is an example of such differentiation. The growth of the American Nursing Association, although it did not emerge from the American Medical Association, has been affected by the actions of physicians. Redefinition of task assignments and role expectations has been a continuous process in medicine, with the functions of the nurse and her claims to professionalism strengthened as she performs the services no longer done by licensed physicians.

New professional associations maintain linkages with established ones through a system of reciprocal obligations. Each owes something to the other and there is a constant struggle over the conditions and extent of these obligations as groups seek a greater pay-off for their own members. The fact of being in a set of relationships governed by reciprocal obligations limits to some degree the freedom of an association to develop its program autonomously.

Linkage among allied professional groups based upon reciprocal obligations also encourages patterns and regularities in the interaction between practitioners and clients. In time, the public learns the functions of each specialty, and the clarity of clients' knowledge is related to the common understandings of practitioners in allied fields concerning their specialized roles.

Finally, the association provides identification for its members and in time develops an ethos which sets the profession apart from others. Its system of training, rites of passage, and formulas for awards and prizes result in a life-long commitment of the individual to the field. The colleague group of which he now becomes a member is the main one in his professional life. He is most concerned about its views and behavior toward him. In large measure, his success or satisfaction with his job is related to his relationships and to the judgments made by his colleagues and peers.[6]

III. PROBLEMS OF PROFESSIONAL ASSOCIATIONS IN COUNSELING

Most professions are represented by one unified, national association with regional and local affiliates. Rehabilitation counseling on the other hand, like a few other occupations undergoing professionalization, is represented by more than one professional association.

The American Psychological Association (APA), with its Counseling Division (17) and Division on Psychological Aspects of Disability (22); the National Rehabilitation Counseling Association (NRCA), a division of the National Rehabilitation Association; and the American Rehabilitation Counseling Association (ARCA), a division of the American Personnel and Guidance Association, are the three associations which span the field.

Informants report that each of these organizations has an appeal to different segments of the profession. APA draws clinical or counseling psychologists with a

doctorate, while ARCA appeals to educators in the field, and NRCA to practicing rehabilitation counselors. Appeal is not the same as practice, however, as will be demonstrated later.

Duplication need not be deleterious to a profession if each association pursues different goals by different methods.[7] Yet, for rehabilitation counseling, having multiple associations in the field does represent something of a problem. One of the main functions of the association is the establishment of a set of professional roles for its members. With more than one association in counseling, the contending groups, each defining rehabilitation counseling somewhat differently, make it difficult to establish a definite role set. This retards the profession's settling upon its "piece of the rehabilitation field" --, i.e. an identity, and thus hinders professionalization.[8]

Lortie[9] suggests that some form of role definition is inevitable. The task can be accomplished either by the profession itself -- and this method is preferred -- or by existing training programs sponsored by educational institutions and supported by government subsidy.

To date, the professional associations in rehabilitation counseling have not reached a consensus on the occupational roles of rehabilitation counselors. The burgeoning need for counseling services in rehabilitation has resulted in government-sponsored training programs with standards and definitions largely determined by staff members of government agencies. The degree to which these role definitions mesh with those of the professional association depends on the extent of exchange between practice, government, and professional association leaders and the degree to which government staff represent the basic interests of the field. The establishment of a clear set of occupational roles for rehabilitation counseling is presently an unfinished task.

One alternative to unanimity in goals, role sets, and a single organization is that each of the three professional associations focus on representing segments of the profession rather than the profession in its entirety. In this model, the need is not for total consensus, but for agreement on which functions and which methods each professional association is to claim. However, the utility of such a model depends on the reality of differences in tasks and roles between segments. Where such differentiation does not exist, division into segments is merely a mask for invidious distinctions and power quests without professional meaning for a particular discipline.

IV. HISTORY OF THE PROFESSIONAL ASSOCIATIONS IN REHABILITATION COUNSELING

A. National Rehabilitation Counseling Association

The National Rehabilitation Association (NRA) was organized in 1925 by administrators and supervisors in civilian rehabilitation, with the goals of securing additional legislation and appropriations in rehabilitation, providing a forum for discussion of problems of disabled civilians, promoting public understanding of rehabilitation, and

developing agreement upon principles and practices. By 1965, the association had over 22,000 members.

In 1957, at the National Conference in Minneapolis, a group of rehabilitation counselors met and approved the establishment of an association to be directed towards the growth and development of the profession of rehabilitation counseling. A national survey of the members of the NRA was undertaken, and support for the formation of a sub-division concerned with counseling was found to be overwhelming. Thus, in October of 1958, at the Asheville, North Carolina conference, the Rehabilitation Counseling Division (RCD) of the NRA was formed.

The goal of the division was the advancement of the role and function of rehabilitation counseling in the rehabilitation of physically and mentally handicapped persons. This goal was to be achieved by the following methods: (1) increasing public understanding; (2) developing professional training opportunities; (3) developing professional standards; and (4) encouraging research in the counseling field. Membership was open to all individuals engaged in counseling, training of counselors, research in the field, or supervision, as well as to graduate students in rehabilitation counselor training. There were no academic qualifications for membership nor different classes of membership.[10]

By 1962, the division had realized the need for a more selective membership policy. Thus various types of membership were set up to go into effect on January 1, 1965. All who joined before this date were to be considered "professional charter members" and did not have to meet any academic or work qualifications except to be working in a rehabilitation setting. Since January 1, 1965, the categories of membership are: "professional membership" for those possessing a minimum of a Master's degree in rehabilitation counseling or a related field, with one year of experience in a rehabilitation setting; "associate membership" for those with a Bachelor's degree employed in the rehabilitation counseling field; and "student membership" for those engaged in graduate study in the field.

In 1963, at its annual meeting in Miami, the RCD became the National Rehabilitation Counseling Association (NRCA), a professional division of the NRA, because the members felt that the use of the word "division" limited the scope, range, and true picture of the activities of the association.[11]

Today membership of NRCA has surpassed 3,900 and is continuing to grow. A national certification board has been established to review credentials for membership. Nine regional and many state chapters are in operation.

The NRA publishes the Journal of Rehabilitation which all members receive. In addition, NRCA publishes the NRCA News four times a year, devoted to news of people and activities in the field, and the NRCA Professional Bulletin, which appears periodically, each issue devoted to a special article of relevance to the rehabilitation counselor. NRCA established a national office and employed an executive director in August, 1965; it has a budget of $44,000 this year. The association is taking

responsibility for establishing a national recruitment and placement service for rehabilitation counseling personnel through a federal grant (VRA) over the next five years.

B. The American Rehabilitation Counseling Association

The American Personnel and Guidance Association was formed in 1952 as a combination of several specialized guidance organizations of many years standing in their fields, including school and college as well as vocational guidance interests. It is a professional association concerned with improving standards of practice, expanding knowledge, and securing appropriate legislation. The Board on Counseling Services evaluates agencies and publishes a biennial directory of those with approved counseling programs. A professional placement service is also maintained for the members.

In 1957 at the Annual Convention, formation of a division concerned exclusively with rehabilitation counseling was discussed. Later that year, influential persons in rehabilitation, including several coordinators of rehabilitation counselor training programs, established themselves as a tentative division 6 of APGA called the Division of Rehabilitation Counseling. On the basis of a petition submitted at the 1958 annual meeting of APGA, the division was formally ratified. The rationale of the founders was that a professional association of rehabilitation counselors could most appropriately fit under the wing of the APGA, because of the parent body's concern with the counseling process, but that a separate group was needed as a focus for the growing store of literature, cross-fertilization of ideas, etc., specifically concerned with rehabilitation counseling.[12]

The purpose of the Division of Rehabilitation Counseling were to foster the rehabilitation of the handicapped by (1) providing and encouraging professional relationships among rehabilitation counselors; (2) encouraging and promoting research in the field and its dissemination; (3) establishing collaboration with the other professional and national organizations in rehabilitation; (4) establishing and maintaining standards of professional competence; and (5) being the leaders in the development of the field of rehabilitation counseling.[13]

At the time of the Division's establishment, there were two classes of membership. Professional membership, with the right to hold office, was open to those who had a Master's degree in a field appropriate to rehabilitation counseling and appropriate work experience. Associate membership was open to those who held a Bachelor's degree, those engaged in fields adjunct to rehabilitation counseling, and students in rehabilitation counseling graduate programs. However, a grandfather clause granted professional membership to all practitioners who joined in the initial two years, from 1958 to 1960. Later, this grandfather clause was extended for another two years, in 1961, when the name was changed from the Division of Rehabilitation Counseling to the American Rehabilitation Counseling Association (ARCA), a division of APGA. Since 1963, the educational and experience requirements for professional membership have been in effect.

At present, ARCA has no unique code of ethics. Members of ARCA subscribe to the APGA code; those holding additional memberships in the National Vocational Guidance

Association, another division of APGA, or in the APA, are bound by these ethical codes also. ARCA and the National Vocational Guidance Association are now cooperating in working out an appropriate code for counseling, and exploring the need for a code specific to rehabilitation counseling.

ARCA does not have any certification machinery. However, it does have the professional level of membership and, beginning this year, a professional certificate is being issued to all those eligible who desire one.

The official publication of the APGA is the Personnel and Guidance Journal, and in addition ARCA issues the Rehabilitation Counseling Bulletin. Dues are $22.00 per year for APGA, plus $2.50 for ARCA membership.

C. The American Psychological Association

Founded in 1892, the American Psychological Association is a well-established professional association, with strict requirements for membership, certification machinery, and provisions for licensure of psychologists achieved in many states. Members cannot "join" the APA, but must be elected to membership. A full membership requires a Ph.D. in psychology plus current work in the field, while associate members must have either two years of graduate study or the M.A. degree with a year of acceptable experience, along with current work in the field. Only after election to APA can an individual become attached to one of the divisions of the organization, such as Division 22, the Division on Psychological Aspects of Disability, which is particularly relevant to rehabilitation concerns, or Division 17, on Counseling Psychology. Dues in APA range from $20 to $45 annually depending on membership status and salary scale; divisional dues are additional.

These divisions are not professional associations in themselves, but represent specialized interests among professional psychologists. Thus there are no "grandfather clauses" permitting entrance to less-qualified practitioners. Whereas a rehabilitation counselor might feel inclined to join NRCA or ARCA as professional organizations in their own right, with the resultant automatic membership in NRA or APGA only an incidental additional benefit, in the case of APA, a counselor who was eligible would join the parent body as the professional association, owing it his major allegiance, while affiliating to Division 17 or 22 only as a mode of enhancing his area of specialization. The code of ethics of APA applies to all members, including those in the various divisions.

Strictly speaking, the APA became a professional association for the first time in 1944, when it merged with the American Association for Applied Psychology. At that time the phrase "to advance psychology as a profession" was initially added to the objectives in the constitution, and eighteen divisions were formed, including Division 17, then called Division of Counseling and Guidance.[14] Membership requirements, only slightly less stringent than those presently in force, were continued from the previous constitutions of the merging organizations. The only concession similar to a "grandfather clause" was that prior membership status in either organization was continued unchanged in the new APA.

In 1952 a special conference of Division 17 for the first time established standards for training counselors, and in 1954 the Division changed its name to Division of Counseling Psychology. The American Board of Examiners in Professional Psychology, an arm of the APA, issues Diplomas in Counseling and Guidance to members with the Ph.D., plus five years counseling psychology experience and satisfactory performance on special diplomate examinations.[15] Among the many journals published by the APA, the Journal of Counseling Psychology is particularly relevant to Division 17.

Division 22, Division on Psychological Aspects of Disability, was initiated during the early 1950's as a special interest group, by APA members who were disturbed by the inadequate attention given to physical disability as an area of study and application of psychological principles. In 1958 the group was formally awarded divisional status in APA under its present name. In that year also a conference at Princeton on Psychology and Rehabilitation spurred interest in this hitherto neglected area.[16] Division 22 gave some attention to an appropriate name. The term "physical" disability in the name was rejected because of a feeling that rehabilitation philosophy covered a broader field than physical ills. The division focusses on research and theoretical interests and has had no direct concern with certification problems.[17] Three times a year a Bulletin of Division 22 is issued, containing both theoretical articles and divisional news.

Rehabilitation counselors with allegiance to the American Psychological Association as their professional group would have to join both Division 17 and Division 22 to cover their area of specialization.

V. MEMBERSHIP PATTERNS

As part of the larger study, lists of all persons engaged in counseling were obtained in the Spring of 1965 from all the Veterans Administration (VA) Hospitals and Benefits offices, from State Vocational Rehabilitation agencies (BVR) in all 50 states and Puerto Rico, and from 427 out of a total of 459 private agencies.[18] Titles were found to differ according to institutional affiliation; thus criteria for inclusion in the counseling population had to be established. In the VA, all Veterans Benefits counseling psychologists were included, plus VA Hospital psychologists who performed counseling duties at least one-third of their time. The criterion for inclusion differed in the private agencies, which tended to have a greater range of job titles. The decision was made to include as "counseling personnel" all individuals who performed rehabilitation counseling duties at least 20 percent of their time, regardless of their actual title. In the BVR, all counselors carrying a case load were included, as were supervisors, the only exclusively supervisory group in the population.[19] In all, a list of 4,559 persons engaged in rehabilitation counseling or supervision was compiled (Table 1).

Membership lists as of February 1965 were secured from ARCA and NRCA as well as from the 1964 APA directory.[20] The roster of 4,559 counselors and BVR supervisors was then checked against the three membership lists, and patterns of memberships in various rehabilitation settings were charted. In addition, in many settings, membership was broken down into regional areas, based on U.S. Census divisions.

TABLE 1

TOTAL STUDY POPULATION

Category	Number
V.A.	363
Benefits	166
Hospitals	197
Private Agencies	586
General	499
Blind	87
BVR	3,610
Supervisors	780
Counselors	2,830
TOTAL	4,559

Of all people engaged in rehabilitation counseling or BVR supervision in early 1965, 59 percent were members of a professional association. This can be compared with physicians, about 75 percent of whom are members of the American Medical Association.[21] Merton has noted that the AMA can claim "substantially higher approximation(s) to completeness than most other professional associations."[22] This might indicate that rehabilitation counselors approach the average in their professional association memberships, except that counselors are dispersed in several organizations. Moreover, while 59 percent of all engaged in counseling hold memberships, this figure varies considerably by institutional affiliation, from a low of 28 percent in private agencies to a high of 64 percent in the BVR (Table 2).

Each setting, furthermore, shows a different type of membership pattern related to the character of counseling duties performed. VA membership is concentrated in APA (79%), an expected finding since the interests of VA personnel are grounded in psychology.

As for the private agencies, membership is more or less equally divided between the three organizations, with a slight preference (44%) for NRCA. However, it must be noted that people employed in private agencies have very diverse backgrounds, if judged from job titles, and thus several professional associations may attract personnel in the group.

TABLE 2

DIFFERENCES IN PERCENTAGE AND TYPE OF PROFESSIONAL MEMBERSHIP BY INSTITUTIONAL AFFILIATION

Category	Total	Members No.	Members %	Memberships No.[a]	Memberships Total %	Memberships ARCA %	Memberships NRCA %	Memberships APA %	Memberships Per Member
Total	4,559	2,691	59.0	2,836	100.0	8.1	81.8	10.1	1.054
VA	363	222	61.2	249	100.0	16.9[b]	4.4[b]	78.7[b]	1.122
Private	586	166	28.3[b]	197	100.1[c]	25.4[b]	44.2[b]	30.5[b]	1.187
BVR	3,610	2,303	63.8[b]	2,390	100.0	5.7[b]	93.0[b]	1.3[b]	1.038

[a] More than total members since average number of memberships per member = 1.054.

[b] Difference from total statistically significant at .05 level or less.[23]

[c] In this and subsequent tables, total percent may vary by .1 because of rounding error.

Within the BVR, membership is very heavily concentrated in NRCA (93%). APA has very little representation (1.3%), probably because few personnel in the state agencies have the necessary credentials in psychology. ARCA also attracts a very small percentage of members - less than six percent.

It is noteworthy that very few people in any counseling setting hold multiple memberships in the three organizations: the average number of memberships per member is 1.05. There are slight variations by institutional affiliation, the average number of memberships for VA personnel is 1.12 and for private agency employees 1.19, while in the BVR the figure is 1.04. Thus, less than ten percent of the personnel in rehabilitation counseling "solve" the problem of multiple professional associations by belonging to more than one. In fact, the findings indicate that each setting has its own unique pattern of professional affiliations significantly different from the others.

In addition to differences between settings, there are variations within each setting according to several occupational and regional characteristics, which are examined below.

A. Veterans Administration

In the VA, counseling psychologists are employed in either Hospitals or offices of Veterans Benefits. Those employed in Hospitals, for the most part, are required to have doctorates in psychology and accordingly might be more likely to belong to a professional association and specifically to APA. The data in Table 3, comparing VA Hospital and VA Benefits office memberships, bear this out.

TABLE 3

DIFFERENCES IN PERCENTAGE AND TYPE OF VA MEMBERSHIP
BY INSTITUTIONAL AFFILIATION

Category	Total	Members		Memberships				
		No.	%	No.[a]	Total %	ARCA %	NRCA %	APA %
Total VA	363	222	61.2	249	100.0	16.9	4.4	78.7
Benefits	166	67	40.4[b]	75	100.0	32.0[b]	5.3	62.7[b]
Hospitals	197	155	78.7[b]	174	99.9	10.3[b]	4.0	85.6[b]

[a] More than total members since average number of memberships per member = 1.12.

[b] Difference from total statistically significant at .05 level or less.

Seventy-nine percent of counseling personnel in VA Hospitals are members of a professional association, as opposed to only 40 percent in Benefits offices. Among those holding memberships, 86 percent in Hospitals belong to APA, compared to only 63 percent in Benefits. Very few in either institutional setting have joined NRCA, five percent or less, while those in Benefits are significantly more likely to be members of ARCA (32%) than those in Hospital settings (10%).

Within the VA, personnel tend to be geographically mobile, as a consequence of institutional policies, with considerable transferring from location to location. This should tend to erase any regional differences in membership, as indeed is indicated by Tables 4 and 5. There are no significant variations in total proportions of members, or in the proportions who belong to ARCA, NRCA, or APA, among VA Counselors in the North East, North Central, Southern, and Western[24] regions of the United States. This holds true whether the psychologists are in Veterans Benefits offices or in VA Hospitals.

TABLE 4

DIFFERENCES IN PERCENTAGE AND TYPE OF PROFESSIONAL MEMBERSHIPS
IN V.A. HOSPITALS BY REGION

Category	Total	Members		Memberships				
		No.	%	No.[a]	Total %	ARCA %	NRCA %	APA %
Total VA Hospital	197	155	78.7	174	99.9	10.3	4.0	85.6
North East	74	58	78.4	69	100.0	14.5	5.8	79.7
North Central	62	44	71.0	47	100.0	8.5	4.3	87.2
South	35	31	88.6	34	99.9	8.8	2.9	88.2
West	26	22	84.6	24	100.0	4.2	0.0	95.8

[a] More than total members since average number of memberships per member = 1.129.

TABLE 5

DIFFERENCES IN PERCENTAGE AND TYPE OF PROFESSIONAL MEMBERSHIPS IN V.A. BENEFITS OFFICES BY REGION

Category	Total	Members No.	Members %	Memberships No.[a]	Memberships Total %	Memberships ARCA %	Memberships NRCA %	Memberships APA %
Total VA Benefits	166	67	40.4	75	100.0	32.0	5.3	62.7
North East	34	13	38.2	15	100.0	20.0	6.7	73.3
North Central	46	20	43.5	22	100.0	50.0	0.0	50.0
South	60	22	36.7	24	100.0	16.7	12.5	70.8
West	26	12	46.2	14	100.0	42.9	0.0	57.1

[a] More than total members since average number of memberships per member = 1.119.

B. Private Rehabilitation Agencies

For the purposes of this analysis, private rehabilitation agencies are classified into two groups - those dealing with all disabilities and those dealing exclusively with the blind. As Table 2 shows, private agencies provide the only instance where less than half the personnel are members of one of the associations studied (28%), a distinct reversal from the patterns seen within the VA and BVR. However, it should be recalled that personnel in private agencies may well be members of other professional associations not included in this analysis. Since many counselors in private agencies do not identify themselves as rehabilitation counselors, but consider themselves social workers or workers with the blind, they may have such allegiances as the National Association of Social Workers or the American Association of Workers for the Blind. If so, this is an indication of further fragmentation of professional associations in the counseling field, as workers affiliate themselves to ancillary groups more basic to their own professional training but not necessarily specialized for rehabilitation.

Private agency memberships are rather uniformly distributed among the three associations. Although NRCA claims a somewhat larger proportion, 44 percent, ARCA members constitute 25 percent and APA, 31 percent. This is in marked contrast to the VA counselors with predominant affiliation in APA, and BVR's, with their concentration in NRCA. Further, although there are some moderate differences by setting, variations are not significant (Table 6).

TABLE 6

DIFFERENCES IN PERCENTAGE AND TYPES OF PROFESSIONAL MEMBERSHIPS IN PRIVATE AGENCIES BY SETTING

Category	Total	Members		Memberships				
		No.	%	No.[a]	Total %	ARCA %	NRCA %	APA %
Total Pvt.	586	166	28.3	197	100.1	25.4	44.2	30.5
General	499	151	30.3	181	100.0	25.4	43.1	31.5
Blind	87	15	17.2[b]	16	100.1	25.0	56.3	18.8

[a] More than total members since average number of memberships per member = 1.187.

[b] Difference from total statistically significant at .05 level or less.

Regional distinctions in proportion of total memberships (Table 7) in the general private agencies[25] are also insignificant. However, geographical variations do appear by specific organization. Private agency members in the North Central region are apt to be NRCA affiliates, while those in the West are disproportionately in APA.

TABLE 7

DIFFERENCES IN PERCENTAGE AND TYPES OF PROFESSIONAL MEMBERSHIPS IN PRIVATE GENERAL AGENCIES BY REGION

Category	Total	Members		Memberships				
		No.	%	No.[a]	Total %	ARCA %	NRCA %	APA %
Total	499	151	30.3	181	100.0	25.4	43.1	31.5
North East	161	58	36.0	75	100.0	32.0	36.0	32.0
North Central	228	62	27.2	72	99.9	20.8	56.9[b]	22.2
South	67	19	28.4	21	100.0	23.8	38.1	38.1
West	43	12	27.9	13	100.0	15.4	15.4[b]	69.2[b]

[a] More than total members since average number of memberships per member = 1.199.

[b] Difference from total statistically significant at .05 level or less.

C. State Vocational Rehabilitation Agencies

Personnel surveyed in the BVR fall into two categories - supervisory and counseling. As Table 8 shows there are no significant differences in membership on this basis. Sixty-four percent of all personnel studied in the BVR are members of a pro-

fessional association. Although slightly more supervisors (66%) are members than counselors (63%), this difference is not significant.

TABLE 8

DIFFERENCES IN PERCENTAGE AND TYPE OF PROFESSIONAL MEMBERSHIPS IN THE BVR BY LEVEL

Category	Total	Members No.	Members %	Memberships No.[a]	Memberships Total %	Memberships ARCA %	Memberships NRCA %	Memberships APA %
Total BVR	3,610	2,303	63.8	2,390	100.0	5.7	93.0	1.3
Supervisors	780	517	66.3	544	100.0	6.3	91.9	1.6[b]
Non-supervisory	2,830	1,786	63.0	1,846	100.0	5.6	93.3	1.1

[a] More than total members since average number of memberships per member = 1.038.
[b] Difference from total statistically significant at .05 level or less.

BVR membership tends to be overwhelmingly in NRCA (93%), and the percentages are very similar among supervisors and counselors. ARCA, with six percent of the membership and APA with only about one percent also show very little differentiation on this level.

Regionally, there are some marked differences in membership in the total BVR group (Table 9). The South has the highest proportion of memberships (74%) along with the highest proportion of NRCA affiliates (98%) and conversely the lowest membership rates in either ARCA (2%) or APA (1%). The West has a lower proportion of total memberships (51%), but the highest rate of ARCA affiliations (13%). The North East ranks last in percentage of memberships (49%), but like the West has relatively higher proportions in ARCA (10%) and APA (2%). The North Central region, which has a high proportion of total memberships (69%), approaches the average distribution of affiliations to the three professional associations.

TABLE 9

DIFFERENCES IN PERCENTAGES AND TYPES OF PROFESSIONAL MEMBERSHIPS IN THE BVR BY REGION

Category	Total	Members No.	Members %	Memberships No.[a]	Memberships Total %	Memberships ARCA %	Memberships NRCA %	Memberships APA %
Total BVR	3,610	2,303	63.8	2,390	100.0	5.7	93.0	1.3
North East	792	390	49.2[b]	418	100.1	9.6[b]	88.3[b]	2.2[b]
North Central	797	553	69.4[b]	581	100.0	7.1	91.4	1.5
South	1,475	1,084	73.5[b]	1,098	99.9	1.7[b]	97.7[b]	0.5
West	546	276	50.6[b]	293	99.9	12.6[b]	85.3[b]	2.0

[a] More than total members since average number of memberships per member = 1.038.
[b] Difference from total statistically significant at .05 level or less.

When counselors and supervisors are examined separately by region, some slight changes appear in these patterns of membership (Tables 10 and 11). Thus the South has the highest proportion of counselor members, while the North Central has the highest proportion of supervisor members.

TABLE 10

DIFFERENCES IN PERCENTAGE AND TYPE OF PROFESSIONAL MEMBERSHIPS AMONG BVR SUPERVISORS BY REGION

Category	Total	Members		Memberships				
		No.	%	No.[a]	Total %	ARCA %	NRCA %	APA %
Total BVR Supervisors	780	517	66.3	544	100.0	6.3	91.9	1.8
North East	128	55	43.0[b]	61	100.1	11.5	85.3	3.3
North Central	211	161	76.3[b]	175	100.0	8.6	87.4[b]	4.0
South	322	235	73.0[b]	238	100.0	1.3[b]	98.3[b]	0.4
West	119	66	55.5[b]	70	100.0	12.9[b]	87.1	0.0

[a] More than total members since average number of memberships per member = 1.052.

[b] Difference from total statistically significant at .05 level or less.

TABLE 11

DIFFERENCES IN PERCENTAGE AND TYPE OF PROFESSIONAL MEMBERSHIPS AMONG BVR NON-SUPERVISORY PERSONNEL BY REGION

Category	Total	Members		Memberships				
		No.	%	No.[a]	Total %	ARCA %	NRCA %	APA %
Total BVR Non-supervisory	2,830	1,786	63.1	1,846	99.9	5.6	93.3	1.1
North East	664	335	50.5[b]	357	100.0	9.5[b]	88.5[b]	2.0
North Central	586	392	66.9	406	100.0	6.4	93.1	0.5
South	1,153	849	73.6[b]	860	100.1	1.9[b]	97.6[b]	0.6
West	427	210	49.2[b]	223	100.1	12.6[b]	84.8[b]	2.7[b]

[a] More than total members since average number of memberships per member = 1.034.

[b] Difference from total statistically significant at .05 level or less.

As with the total group, the North East and West show the largest percentages of ARCA memberships, from ten to about 13 percent, with somewhat higher rates among supervisors. APA commands support of only a tiny minority, the highest being four percent among North Central supervisors. Among both supervisors and counselors, the major associational affiliation is with NRCA.

Generally, one would expect professional membership to be more characteristic of supervisors than of counselors on the grounds that the "elite" in a field would be most concerned with upgrading practice through the professional association. But the figures indicate that in the South there is virtually no difference in the membership rate and in the North East a somewhat higher percentage of counselors than of supervisors are members.

One possible explanation is the initiation and success of membership drives. Apparently, in some regions campaigns have been conducted by supervisors, counselors or both whereby entire staffs joined NRCA. Affiliation rates ranging from 85 to 98 percent, as well as information gleaned from newsletters, are tangible evidence of this procedure. In such circumstances minor variations between the "elite" and the "rank and file" are of little consequence. Also, it is noteworthy that the North East and Western regions, which show the lowest total proportions of memberships among both supervisors and counselors, are also the areas with the highest rates of ARCA memberships. This hints that differences concerning the appropriateness of the two competing professional associations may have resulted in a large number of both counselors and supervisors joining neither.

D. State By State Analysis

Regional analysis obscures some interesting data on state differences in membership distribution within the Bureaus of Vocational Rehabilitation. For example, if NRCA membership is plotted on a state-by-state basis, it reveals that eight states have 80 percent or more BVR counselors in the association (Figure 1 and Table 12). Five of these - Alabama, Texas, Mississippi, Georgia, and Delaware - are in the South, with Pennsylvania in the North East, Indiana in the North Central, and Hawaii in the West. Two states, New York and Arizona, have less than 20 percent of their BVR counseling staff in NRCA.

TABLE 12

PERCENTAGE OF BVR COUNSELING PERSONNEL HOLDING MEMBERSHIPS IN ARCA AND NRCA

Region and State	Total N	ARCA Membership %	NRCA Membership %	Duplicate Memberships in ARCA and NRCA %
NORTH EAST	664	5.1	47.6	2.9
Connecticut	28	7.1	42.9	3.6
Maine	14	0.0	42.9	0.0
Massachusetts	58	6.9	37.9	5.2
New Hampshire	6	0.0	33.3	0.0
New Jersey	97	5.2	27.8	2.1
New York	182	8.2	13.2	3.3
Pennsylvania	230	3.5	80.4	3.0
Rhode Island	38	0.0	78.9	0.0
Vermont	11	0.0	72.7	0.0
NORTH CENTRAL	586	4.4	64.5	2.2
Illinois	100	2.0	73.0	2.0
Indiana	32	0.0	84.4	0.0
Iowa	44	6.8	70.5	2.3
Kansas	32	0.0	71.9	0.0
Michigan	73	6.8	67.1	4.1
Minnesota	71	7.0	46.5	2.8
Missouri	64	4.7	56 3	3.1
Nebraska	28	7.1	78.6	3.6
North Dakota	11	0.0	63.6	0.0
Ohio	62	4.8	67.7	1.6
South Dakota	13	7.7	61.5	0.0
Wisconsin	56	3.6	48.2	1.8

TABLE 12 - Continued

Region and State	Total N	ARCA Membership %	NRCA Membership %	Duplicate Memberships in ARCA and NRCA %
SOUTH	1153	1.4	72.7	.7
Alabama	47	2.1	80.9	0.0
Arkansas	57	1.8	71.9	1.8
District of Columbia	37	13.5	59.5	10.8
Delaware	10	0.0	100.0	0.0
Florida	110	.9	73.6	0.0
Georgia	135	1.5	81.5	0.0
Kentucky	60	1.7	53.3	1.7
Louisiana	57	0.0	71.9	0.0
Maryland	51	2.0	74.5	2.0
Mississippi	42	2.4	90.5	2.4
North Carolina	73	0.0	68.5	0.0
Oklahoma	62	0.0	79.0	0.0
Puerto Rico	33	0.0	18.2	0.0
South Carolina	71	1.4	71.8	0.0
Tennessee	57	1.8	70.2	0.0
Texas	139	.7	82.0	0.0
Virginia	46	0.0	78.3	0.0
West Virginia	66	0.0	68.2	0.0
WEST	427	6.6	44.3	1.9
Alaska	10	0.0	50.0	0.0
Arizona	27	7.4	3.7	0.0
California	191	10.5	31.9	1.6
Colorado	43	2.3	74.4	2.3
Hawaii	18	5.6	83.3	5.6
Idaho	8	12.5	62.5	12.5
Montana	12	0.0	58.3	0.0
Nevada	8	0.0	25.0	0.0
New Mexico	7	0.0	28.6	0.0
Oregon	34	2.9	41.2	0.0
Utah	14	0.0	78.6	0.0
Washington	43	4.7	67.4	4.7
Wyoming	12	0.0	41.7	0.0

FIGURE 1 - PERCENTAGE OF STATE BVR COUNSELORS WHO ARE MEMBERS OF THE NATIONAL REHABILITATION COUNSELING ASSOCIATION (NRCA), FEBRUARY, 1965.

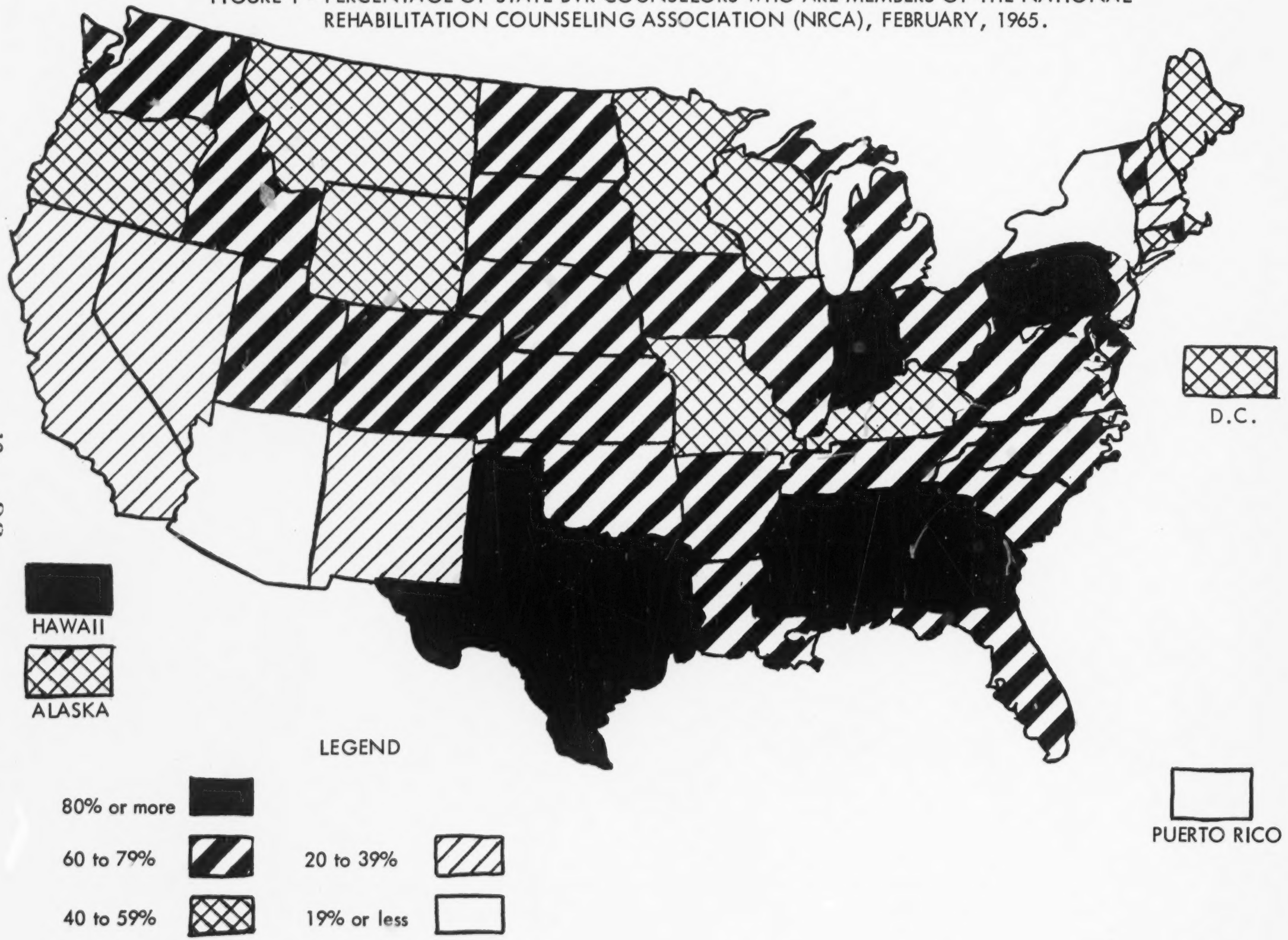
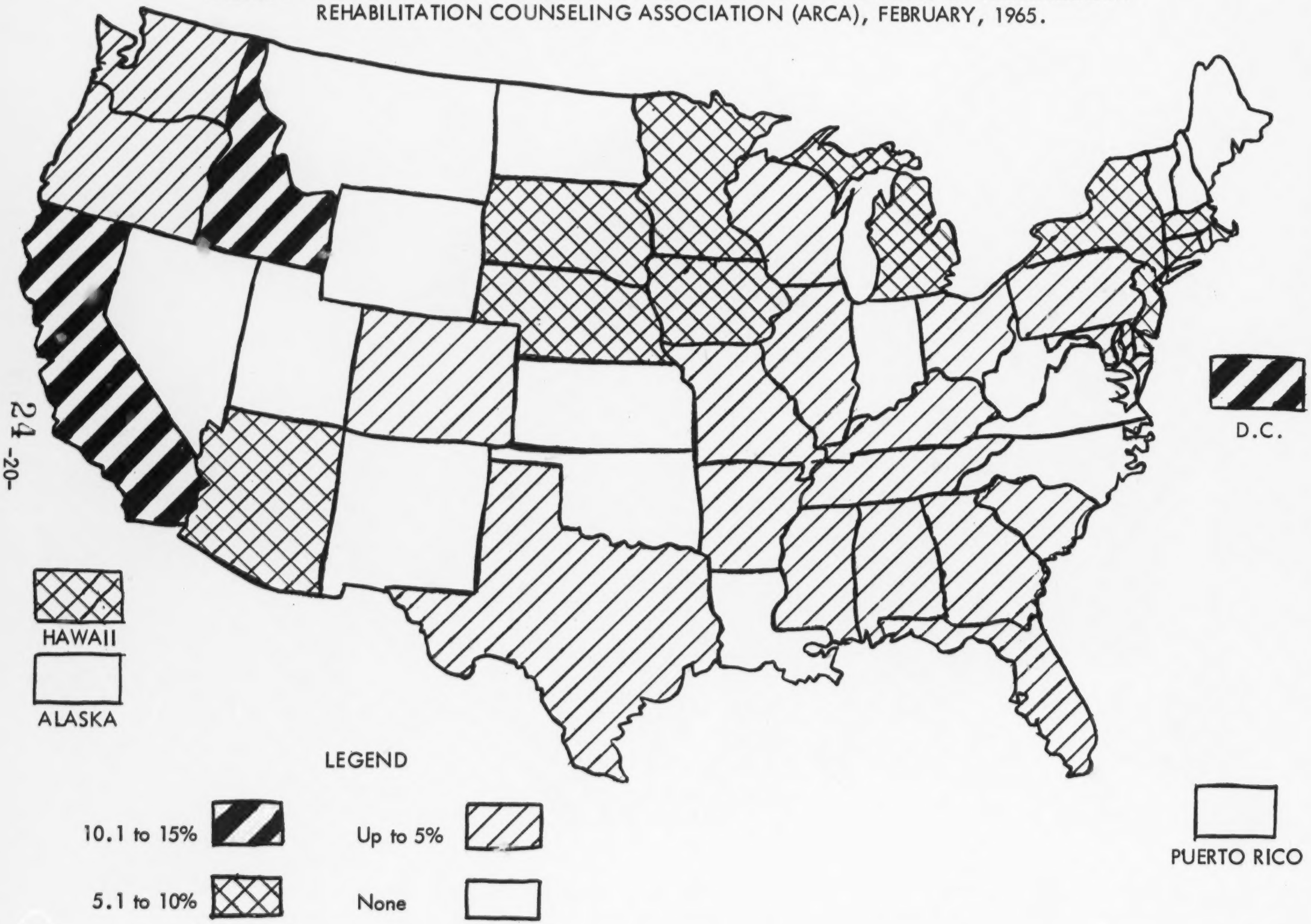


FIGURE 2 - PERCENTAGE OF STATE BVR COUNSELORS WHO ARE MEMBERS OF THE AMERICAN REHABILITATION COUNSELING ASSOCIATION (ARCA), FEBRUARY, 1965.



As for ARCA (Figure 2 and Table 12), 19 states have no members of this group among their BVR counselors, including six in the South and six in the West. Only two states, California and Idaho, and the District of Columbia, have 10 percent or more, and none run above 15 percent.

Among the supervisors, the breakdowns show more states relatively high in NRCA membership than was evidenced among the counselors. In 16 states, 80 percent or more of the supervisors are in this association, including eight in the South, two in the North East, four in the North Central, and two in the West. One state, Wyoming, has less than 20 percent of its supervisory personnel in NRCA (Figure 3 and Table 13).

Similarly, more states have substantial minorities of ARCA memberships among supervisors than was found to be true of counselors (Figure 4). Six states have membership rates above 15 percent -- New York and Connecticut in the North East; Iowa in the North Central; and Nevada, Idaho, and Colorado in the West. Thirty-five states have no supervisory ARCA members, including all but three of the 16 Southern states.

It is apparently true that certain large states in the North East and West, such as New York and California, are relatively low in NRCA membership and relatively high in ARCA affiliations, although neither group has commanded the allegiance of a majority of the staff.

TABLE 13

PERCENTAGE OF BVR SUPERVISORY PERSONNEL HOLDING MEMBERSHIPS IN ARCA AND NRCA

Region and State	Total N	ARCA Membership %	NRCA Membership %	Duplicate Memberships in ARCA and NRCA %
NORTH EAST	128	5.5	40.6	3.1
Connecticut	9	33.3	77.8	22.2
Maine	4	0.0	25.0	0.0
Massachusetts	21	0.0	33.3	0.0
New Hampshire	2	0.0	100.0	0.0
New Jersey	15	0.0	13.3	0.0
New York	25	16.0	28.0	8.0
Pennsylvania	39	0.0	41.0	0.0
Rhode Island	7	0.0	71.4	0.0
Vermont	6	0.0	83.3	0.0

TABLE 13 - Continued

Region and State	Total N	ARCA Membership %	NRCA Membership %	Duplicate Memberships in ARCA and NRCA %
NORTH CENTRAL	211	6.6	78.7	5.7
Illinois	22	4.5	95.5	4.5
Indiana	10	0.0	90.0	0.0
Iowa	18	16.7	61.1	11.1
Kansas	7	0.0	71.4	0.0
Michigan	35	11.4	68.6	11.4
Minnesota	22	9.1	50.0	4.5
Missouri	15	0.0	66.7	0.0
Nebraska	10	0.0	70.0	0.0
North Dakota	8	0.0	100.0	0.0
Ohio	34	14.7	85.3	11.8
South Dakota	12	0.0	58.3	0.0
Wisconsin	18	0.0	61.1	0.0
SOUTH	322	.9	72.7	.6
Alabama	22	0.0	86.4	0.0
Arkansas	23	0.0	52.2	0.0
District of Columbia	7	0.0	85.7	0.0
Delaware	7	0.0	42.9	0.0
Florida	31	3.2	83.9	3.2
Georgia	19	0.0	84.2	0.0
Kentucky	13	0.0	69.2	0.0
Louisiana	12	0.0	41.7	0.0
Maryland	11	0.0	100.0	0.0
Mississippi	11	0.0	81.8	0.0
North Carolina	25	0.0	88.0	0.0
Oklahoma	19	0.0	78.9	0.0
Puerto Rico	22	0.0	50.0	0.0
South Carolina	12	0.0	66.7	0.0
Tennessee	15	6.7	53.3	0.0
Texas	20	0.0	75.0	0.0
Virginia	20	5.0	60.0	5.0
West Virginia	33	0.0	81.8	0.0

TABLE 13 - Continued

Region and State	Total N	ARCA Membership %	NRCA Membership %	Duplicate Memberships in ARCA and NRCA %
WEST	119	7.6	57.3	3.4
Alaska	2	0.0	100.0	0.0
Arizona	9	0.0	22.2	0.0
California	27	11.1	37.0	3.7
Colorado	12	25.0	58.3	16.7
Hawaii	12	0.0	50.0	0.0
Idaho	4	25.0	50.0	0.0
Montana	8	0.0	75.0	0.0
Nevada	5	20.0	100.0	20.0
New Mexico	8	0.0	37.5	0.0
Oregon	10	10.0	70.0	0.0
Utah	9	0.0	77.8	0.0
Washington	11	0.0	36.4	0.0
Wyoming	2	0.0	0.0	0.0

In other states, particularly in the Southern and North Central regions, NRCA can speak for large majorities of both counselors and supervisors, but ARCA affiliations are practically nonexistent. The implication is that NRCA, even in the BVR where its greatest strength lies, has not been able to convince the counseling group uniformly throughout the country of its importance as the one association for the emerging profession.

An opinion current in the field is that, pending such consensus, there is much overlapping membership between NRCA and ARCA; however Tables 12 and 13 indicate otherwise. Only very small minorities in any state have joined both associations, with the highest proportion of dual memberships among counselors occurring in the District of Columbia with 11 percent and Idaho with 12.5 percent. Among supervisors, the overlap is somewhat greater in those states where any ARCA affiliations exist. Thus in Connecticut 22 percent of supervisors hold memberships in both associations, 20 percent in Nevada, 17 percent in Colorado, and 11 percent each in Iowa and Michigan. Even so, it is clear from this state analysis that relatively few counselors and supervisors have seen the need of joining both groups. One practical explanation is that membership fees in NRCA are $10 annually, and in ARCA $24.50 per year; the total of $34.50 may be a formidable sum for many in the field.

FIGURE 3 - PERCENTAGE OF STATE BVR SUPERVISORS WHO ARE MEMBERS OF THE NATIONAL REHABILITATION COUNSELING ASSOCIATION (NRCA), FEBRUARY, 1965.

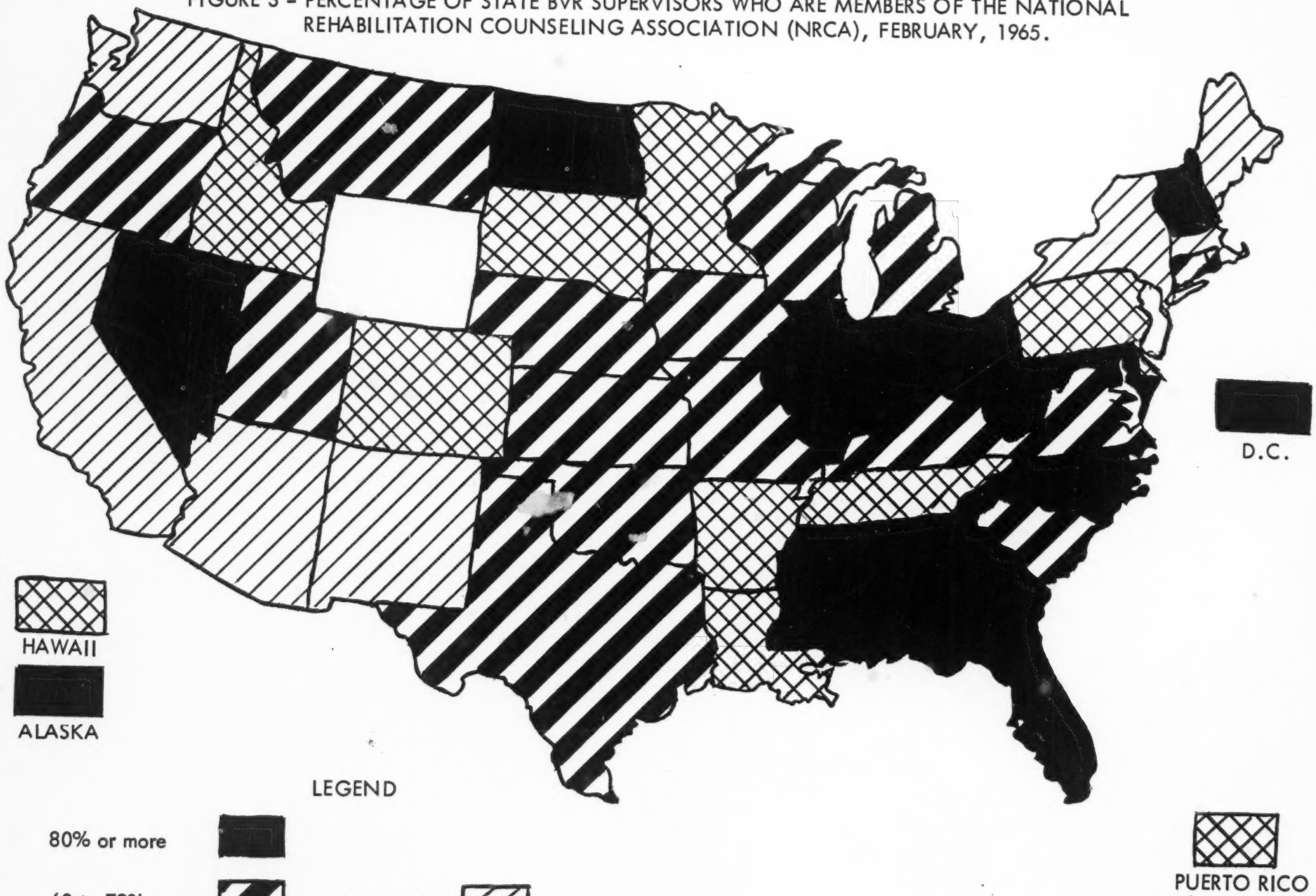
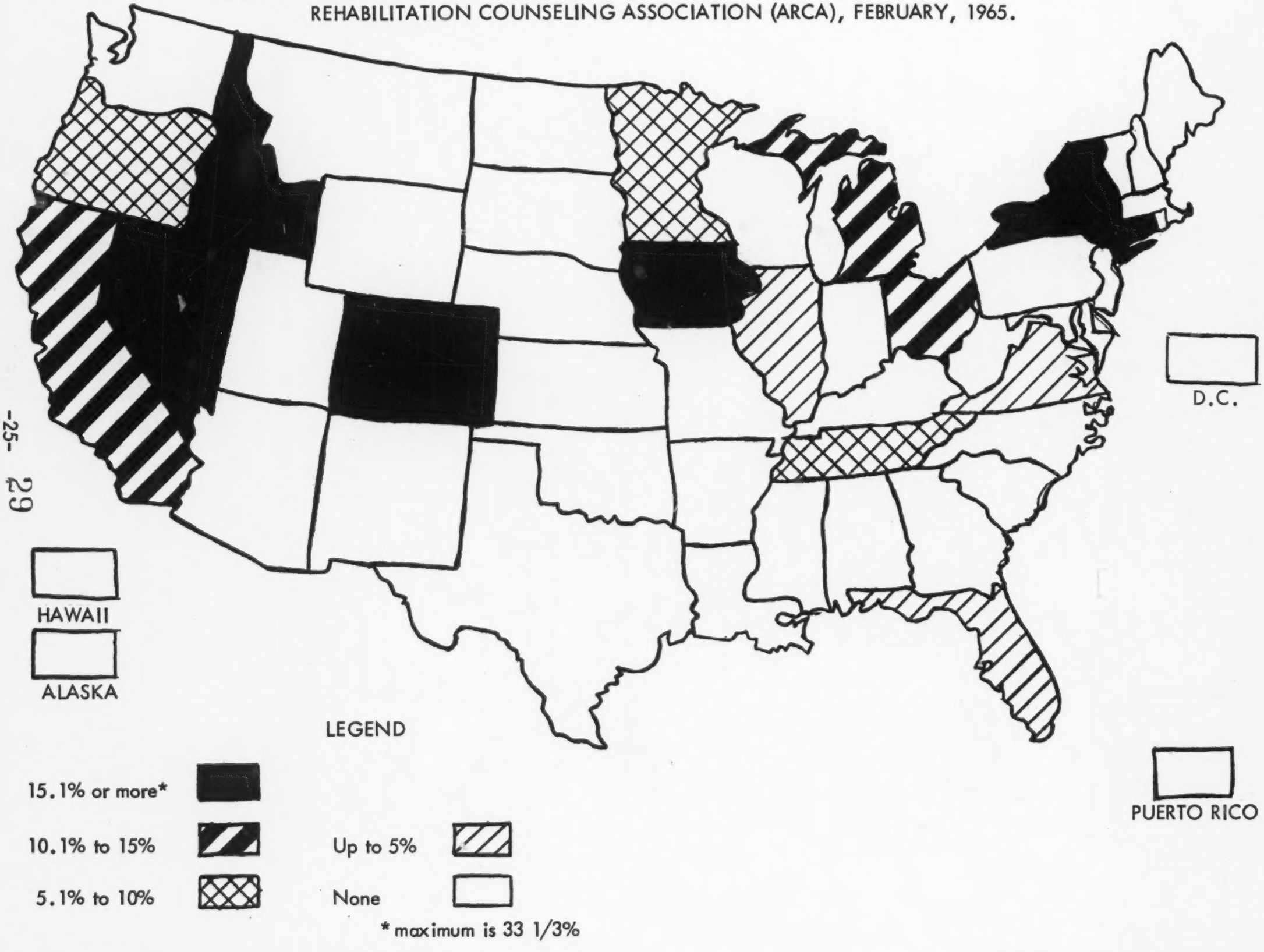


FIGURE 4 - PERCENTAGE OF STATE BVR SUPERVISORS WHO ARE MEMBERS OF THE AMERICAN REHABILITATION COUNSELING ASSOCIATION (ARCA), FEBRUARY, 1965.



VI. CONCLUSIONS

The data presented here are preliminary findings of a larger study on the Career Contingencies of the Rehabilitation Counselor. Their implications must, of necessity, be impressionistic and tentative, pending analysis of more detailed data from a direct survey of the field. However some initial conclusions may be drawn.

First, it is clear that association memberships differ greatly according to the institutional milieu in which counseling tasks are performed. VA personnel are concentrated in APA, and BVR counselors in NRCA, while private agency workers divide their associations fairly evenly among APA, NRCA, and ARCA. It is also suspected, because of the wide variance in job titles in private agencies, that many workers in these settings are members of other professional groups, in social work or in special disability areas. In addition, the rate of memberships varies by setting, ranging from 28 percent for the private groups to 61 percent and 63 percent for the VA and BVR respectively.

Multiple memberships are not widely utilized by counselors: less than ten percent of incumbents belong to more than one of the three organizations under review.

Geographical place of work also affects membership rates, but largely on the basis of type of setting. Whether a VA counselor is located in the North East, North Central, South, or West has little impact on his professional affiliation. Regional differences in organizational affiliations in private agencies are also chiefly chance variations except for disproportionately more NRCA memberships in the North Central states and APA memberships in the West.

In the BVR, however, affiliations of both counselors and supervisors vary by region, with lowest proportions of memberships in the North East and West, and highest in the North Central and South, for both job levels. Type of membership differs regionally also. Western BVR supervisors are disproportionately in ARCA, and Southern in NRCA, while both North Eastern and Western counselors turn up more frequently than expected in ARCA, and Southern Counselors more frequently in NRCA. Regional groupings obscure wide differentiations between states. Both ARCA and NRCA memberships tend to be bunched in certain states within regions. ARCA shows the highest rates in New York and California, which also tend to be relatively low in NRCA memberships. According to data collected elsewhere in this study, these two states have high prestige among rehabilitation counseling students as "the best." Further analysis will explore some facets of this image on the basis of data compiled in the larger research enterprise. Such analysis may also throw light on factors associated with different rates and types of memberships in the three associations under review.

At this juncture, the analysis of professional association affiliations in different work settings and different regions of the United States strongly suggests that there is no single organization which can speak in a united voice for the needs of rehabilitation counseling as an emerging profession.

However, it can be argued that this "united voice" is not essential, and might even be dysfunctional. This view is based on the variations in focus which seem to characterize the rehabilitation field. While it is true that all rehabilitation workers are concerned with the restoration of the "whole man", there is a different distribution of emphasis on facets of this whole in different institutional settings.

Counselors working in state BVRs are guided by the philosophy and legislative imperatives of the Vocational Rehabilitation Administration. Their major concern is with vocational training and placement; social and psychological factors are largely considered in the context of their effect on employability. Psychologists performing counseling in the VA, on the other hand, emphasize personal adjustment, and view vocational placement in the context of its impact on social and psychological adaptation. The focus of those doing rehabilitation counseling in private settings is less clear; perhaps both emphases are combined, or there is variation by specific agency, or attention is chiefly to the counseling process as such. These are presently empirical questions.

Training requirements differ by institutional setting also. VRA-sponsored training for rehabilitation counseling offers the MA as a terminal degree. Psychologists normally do not consider their education complete without the doctorate, and in fact VA job specifications for counselors in recent years have explicitly demanded the Ph.D. Private agency training standards are unknown, but undoubtedly are not uniform in degree level requirements.

These variations in work emphasis and educational background, which may mirror differences in theoretical orientation, form the basis of the argument that more than one professional association is appropriate for rehabilitation counseling, and that combination in one organization would indeed militate against the maturation of differing segments of the field. The VA counselors' majority affiliations with APA, and the BVR counselors' preponderant allegiance to NRCA are thus not only explainable, but a desirable reflection of current realities. In this view, the fact that both NRCA and ARCA appeal to BVR counselors allows for a useful diversity. NRCA is a part of NRA, an organization concerned primarily with rehabilitation, while ARCA, a division of APGA, gives major attention to the counseling process; both groups are needed to cover the spectrum of counselor interests.

This position, however, presumes the continuation of existing boundaries setting apart segments of the total rehabilitation field. VA counseling psychologists, BVR rehabilitation counselors, and private agency workers are all part of this total field, despite current differences in job title, restoration emphasis, and training. Increasingly the evidence indicates that boundaries are becoming indeterminate. Many VRA training programs are conducted by Departments of Psychology, suggesting interpenetration of segments in educational and theoretical areas. If VA counselors give more attention to vocational placement and BVR counselors to personal adjustment, there can be interpenetration in work areas also. Should boundaries fade, multiple professional associations could retard consensus on role definitions and underlying theory.

In this connection the deliberations of the recent Conference on Government-University Relations in the Professional Preparation and Employment of Counselors are relevant.[26] The trend of the future, it appears, may be to consider counseling itself as an occupational entity, with guidance counseling, employment counseling, rehabilitation counseling and the like, as specialties under the generic type. This would follow the medical model, in which obstetricians, neurologists, internists, etc., are all considered physicians, with the same basic medical training a prelude to particularized studies relevant to their specialties. If this trend matures, the field of rehabilitation will encompass many job titles and institutional settings; old boundaries will vanish and new ones emerge. Some reorganization of present professional associations might be in order.

These issues are thought-provoking, and fascinating in theoretical terms. This working paper does not presume to give any definitive answers. It has sought, however, to encompass the total field, and thereby provide the factual data necessary for further analysis, in greater depth, of the appropriate scope of counseling in rehabilitation, and of the respective merits of unity and diversity in the professional associations open to practitioners in the field.

FOOTNOTES

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16. See Beatrice A. Wright, editor, Psychology and Rehabilitation (Washington: American Psychological Association, 1959) for the proceedings.

17. Conversation with Dr. Beatrice Wright, University of Kansas.

18. This leaves 32 agencies unaccounted for. Five of these reported too late to be included in this analysis, with three indicating no counselors eligible for the study and the remaining two agencies naming eight persons eligible. No replies were ever received from 27 agencies. Twelve of these were regional offices of a state Association for the Blind in small communities usually not having counselors. Of the remaining 15 non-respondent agencies, only one reported counselors on the staff to the Association of Rehabilitation Centers in its 1961 survey as reported in the Journal of Rehabilitation, XXX (May-June, 1964). However the Association's definition of a rehabilitation counselor was more restrictive than the one used here, and it is not possible to make a firm estimate of the number of persons missing on this basis. Using the average counselor rate per responding agency of 1.37, the "lost" members of the population could total 43, although this seems a high number on the other evidence presented here.

19. In a number of VA locations and private agencies, supervisors or directors who met the criteria of performing some counseling duties were also included.

20. The 1965 directory was not yet in circulation.

21. This figure was approximated from 1960 U.S. Census data and the Encyclopedia of Associations, edited by Frank G. Ruffner, Jr., (Detroit: Gale Research Co., 1964).

22. Robert K. Merton, Social Theory and Social Structure, (Glencoe: Free Press, 1959), 314.

23. Chi-square goodness-of-fit tests were run, using the total membership in the category as an approximation of the expected rate of membership.

24. States in the North East region are: Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont. States in the North Central region are: Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin. States in the Southern region are: Alabama, Arkansas, District of Columbia, Delaware, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, Virginia, and West Virginia. States in the Western region are: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

25. Geographical regions among private workers for the blind were not analyzed because of small cells.

26. The proceedings are published as Counselor Development in American Society, edited by John F. McGowan, (Columbia, Mo.: University of Missouri, 1965).